STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from 7/11/17 through 7/19/17. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 166. The Stage 2 survey sample size was 55. Abbreviations/definitions in this 2567 are as follows: 1 to 1 - one staff person assigned direct supervision of a resident; AAO3 - alert and oriented times three/alert and oriented to person, place and time; ADLs - activities of daily living; ADON - Assistant Director of Nursing; amp - ampule/sealed vial made of glass or plastic that contains a sterile medicinal solution or a powder; AKI - Acute kidney injury/ previously called acute renal failure (ARF), is an abrupt loss of kidney function that develops within 7 days; AMS - altered mental status; BG - blood glucose; BID - twice a day; BM - bowel movement; BMP - Basic Metabolic Panel/blood test used to check the status of a person's kidneys and their electrolyte and acid/base balance, as well as their blood glucose level; BS - blood sugar; BUN - Blood Urea Nitrogen/blood test is used to determine how well your kidneys are working. BUN levels tend to increase when the kidneys or liver are damaged; C&S - culture and sensitivity/laboratory test that	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/07/2017

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grows out bacteria and determines which antibiotics are effective against the bacteria;
CAA - Care Area Assessment/summary that assists in identifying potential problem areas;
CBC - Complete Blood Count/blood test used to evaluate overall health and detect a wide range of disorders, the test measures several components and features of one's blood;
CNA - Certified Nurse's Aide;
D/C or d/c or d/ced - discontinued;
DON - Director of Nursing;
D50 - Dextrose 50% /an intravenous injection of dextrose (sugar) used in insulin-induced low blood sugar;
e.g. - for example;
eMAR - electronic Medication Administration Record;
EMS - Emergency Medical Services;
ED/ER - Emergency Department/Emergency Room;
FS - fingerstick/method of pricking finger to obtain blood for testing;
lbs. - pounds;
IM - intramuscular/into a muscle;
IV - intravenous/into a vein;
L - liter/about 1.75 pints/one pint=2 cups;
LPN - Licensed Practical Nurse;
MAR-Medication Administration Record;
MD - Medical Doctor;
MDS - Minimum Data Set/assessment tool used in long term care facilities;
mg - milligram, unit of weight;
ml - milliliter;
NAS - no added salt;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
oz -ounce;
PA - Physician Assistant;
PO/po - by mouth;

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prn - as needed;
PT - Physical Therapy/therapist;
pt - patient;
RD - Registered Dietitian;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
SLP - Speech Language Pathologist;
SSI - sliding scale insulin/a dosing schedule based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher;
STAT - immediately;
UA - urinalysis/laboratory test analyzing urine;
UM - Unit Manager;
w/ - with;
WC or W/C - wheelchair;
WNL - within normal limits;
< - less than;
% - percent.

Accu-Chek - blood fingerstick testing for blood sugar levels;
Alzheimer's - an irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks;
Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak;
Anxiety - unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth;
Ativan-medicaton for anxiety;
Attends - adult briefs/diapers;

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F 000	Continued From page 3 Basaglar KwikPen - long acting insulin used to control blood sugar levels in a disposable, prefilled insulin pen; Creatinine - blood test in which elevated level signifies impaired kidney function or kidney disease; Chux - disposable mattress pad placed under the resident for incontinence; Controlled Drug Receipt/Record/Disposition Form (accountability record) - inventory form that records every dose of a controlled substance administered to a resident; Dehydration - occurs when one's body doesn't have as much water as it needs; Dementia - a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Diabetes Mellitus - elevated blood sugar levels; Draw sheet - narrow sheet placed under the resident's buttocks to keep the linens/mattress dry; Ensure/Ensure Enlive - liquid dietary supplement; Epogen - a manmade form of a human protein that works by stimulating the body to make more red blood cells; Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Glucagon - treatment for insulin coma or insulin reaction resulting from severe low blood sugar; given by injection into a muscle; Hoyer - mechanical lift used to transfer residents to and from various surfaces, e.g. to and from bed to chair; Hypernatremia - elevated blood sodium level;	F 000		

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Hypoglycemia - low blood sugar level;
Humalog - fast acting insulin, injectable medication used to control blood sugar levels;
Incontinent/incontinence - loss of control of bladder &/or bowel function;
Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own
Iron - An essential mineral necessary for the transport of oxygen in the blood stream;
Lantus Insulin - a long acting form of insulin used to control blood sugar levels;
Lethargic - drowsy, sluggish;
Nephrologist - medical doctor dealing with the kidneys;
Nepro - nutritional product/supplement;
Novolog - fast acting insulin, injectable medication used to control blood sugar levels;
Phenergan suppository - medication given via rectum for nausea and/or vomiting;
Promod - oral protein supplement;
Psychotropic - any medication capable of affecting the mind, emotions and behavior;
Seizure - abnormal electrical activity in the brain causing repetitive muscle jerking;
Semi-comatose - lacking awareness and the capacity for sensory perception;
Sodium/Na - an essential electrolyte that helps maintain the balance of water in and around your body's cells;
Somnolent - sleepy, drowsy;
Subcutaneously- injection given into the fat layer between the skin and the muscle;
Underpads - multilayered sheet with high absorbency used for incontinence;
Unit/units/u - measurement used for insulin dosage;

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F 000	Continued From page 5 Unscored - medication tablets without a groove to be cut in half; Vimpat-controlled medication for seizures; Zyprexa - antipsychotic medication.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, it was was determined that for 2 (R175 and R117) out of 55 Stage 2 sampled residents, the facility failed to promote care in a manner and in an environment that maintained or enhanced their dignity and respect in full recognition of their individuality. For R175, the facility failed to provide her with feeding assistance for 21 minutes while her 2 tablemates ate their meals. For R117, the facility failed to serve her meal at the same time as her 3 tablemates. Findings include: 1. An observation on 7/11/17 at 11:32 AM in the Elsmere dining room revealed that a table of 3 residents (R52, R162 and R175) were served their meals. R52 and R162 were observed immediately eating on their own. From 11:32 AM to 11:53 AM, R175 was observed with her meal in front of her untouched until feeding assistance was provided. R175 sat unassisted for 21 minutes with her meal in front of her while her 2 tablemates ate their meals.	F 241	Example 1 A. R175 did receive feeding assistance. B. All residents requiring assistance with meals have the potential to be affected. C. Residents identified as requiring assistance with feeding will receive their tray at the same time as other residents at the table. Upon meal delivery, a staff member will assist the resident. All staff members eligible to assist with feeding will be in-serviced no later than August 28th. D. Supervisor/designee will monitor tray pass for accuracy and compliance each meal to ensure residents are assisted in a timely manner daily for 14 days, then weekly times 10, until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. R117 did receive a meal; this resident	8/28/17

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F 241	Continued From page 6 2. An observation on 7/11/17 at 11:40 AM in the Elsmere dining room revealed only 3 out of 4 (R29, R39, R93 and R117) residents seated at the table were served their meals at the same time. R117 watched her 3 tablemates eat their meals for approximately 11 minutes until she was served her meal at 11:51 AM. Findings were reviewed with E2 (DON) and E3 (RN/Staff Ed) on 7/19/17 at 3 PM. The facility failed to feed and serve R175 and R117 at the same time as their tablemates were eating their meals.	F 241	chose to eat in a different location which contributed to the delay in delivery. B. All residents receiving meals in the dining room have the potential to be affected. C. Residents sitting together at tables will receive their meals at the same time. All staff members participating in tray delivery will be in-serviced no later than August 28th. D. The supervisor/designee will monitor the tray delivery carts each meal to ensure proper order to allow dining room residents to be served efficiently daily for 14 days, weekly times 10, until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide maintenance services for 4 rooms (B12, C3, E3, and E10) out of 36 rooms surveyed. Findings include: The following were observed and confirmed from the stage 1 room checks from 7/11/17 to 7/12/17 and stage 2 environmental tour on 7/14/17 from 10:00 AM to 11:00 AM: Room B12	F 253	Room B12 A. The bathroom call bell panel has been repaired. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 14 days, then two	7/20/17

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F 253	Continued From page 7 The bathroom call bell was functional, but the panel was peeling away; Room E10 There was black tape on the fall mat on the right side of the bed; Room E3 The wall was in disrepair on the right side when entering the bathroom; Room C3 The bathroom sink was draining slow. All issues were reviewed and confirmed by E4 (Maintenance Director) and E5 (Housekeeping Director) on 7/14/17 at approximately 11:00 AM.	F 253	times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported quarterly through the facility QAPI process. Room E10 A. The black tape was removed from the fall mat. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported quarterly through the facility QAPI process. Room E3 A. The wall in the bathroom has been repaired. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported	

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F 253	Continued From page 8	F 253	quarterly through the facility QAPI process. Room C3 A. The bathroom sink has been unclogged. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include examination for the deficient practice(s) found. Repairs will be completed as identified. D. The Maintenance Director or designee will review two resident rooms on each hallway (6) daily for 14 days, then two times per week for two weeks and monthly until 100% compliance has been observed. Findings will be reported quarterly through the facility QAPI process.	
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that temperature levels in the Greenbank dining room were comfortable and did not exceed 81 degrees F. Findings include: During the dining observation in the Greenbank dining room on 7/11/17 at 12:15 PM, R174 was observed at a table, fanning herself with a napkin. Behind her table was a baseboard heater, which	F 257	A. R174 had no untoward effect. It was determined that the heaters had been turned on accidentally during a preventive maintenance visit by the facility HVAC contractor. As noted, the heaters were once again turned off and temperature returned to acceptable levels. B. All residents have the potential to be affected.	7/20/17

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F 257	Continued From page 9 was observed to be turned on. R174 was asked on 7/11/17 at 12:15 PM why she was fanning herself and she stated, "too hot in here." Inspection of the dining room revealed one other baseboard heater that was on, as well as another heater at the entrance to the dining room from the hallway. Measurement of Greenbank dining room's ambient room temperatures on 7/13/17 from 12:10 PM to 12:50 PM showed temperatures ranging from 80.4 degrees F to 84.6 degrees F in the areas with heaters turned on. R174 was observed fanning herself again, stating, "it's hot" in an interview at 12:30 PM. The ambient room temperature measured 83 degrees F where R174 sat. During an interview on 7/14/17 at 1:15 PM, E4 (Maintenance Director) stated that someone must have tampered with the circuit breakers, accidentally turning on the heaters as he had turned them off in May. On 7/17/17 at 2:30PM, ambient room temperatures taken in the Greenbank dining room revealed temperatures ranging from 75.4 degrees F to 78.6 degrees F in the areas where the heaters were turned on previously. All baseboard heaters had been turned off, as confirmed by E4 on 7/18/17 at 8:35 AM. Findings were reviewed with E2 (DON) on 7/19/17 at 5 PM.	F 257	C. Temperature monitoring has been added to the facility maintenance rounds. Any temperatures found below 71 degrees F or above 81 degrees F will be investigated for cause and appropriate repairs made. Breakers for the heaters are also correctly labeled. D. The Maintenance Director or designee will review dining room temperatures for each meal daily for 14 days, then two times per week for two weeks, then monthly until 100% compliance has been observed. Findings will be reported quarterly through the facility QAPI process.	
F 258 SS=D	483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound	F 258		8/28/17

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F 258	Continued From page 10 levels. This REQUIREMENT is not met as evidenced by: Based on an observation, it was determined that for 5 (R5, R70, R115, R126 and R143) out of 55 Stage 2 sampled residents, the facility failed to ensure comfortable sound levels during an activity in the Greenbank lounge. Findings include: An observation on 7/12/17 from 1:05 PM to 1:42 PM in the Greenbank lounge revealed an activity was occurring at the table where R5, R70, R115, R126, R143 and R197 were seated. For approximately 37 minutes, R197 was observed screaming at the top of her voice "I want to be dead" and "I'll kill him" repeatedly at the table interrupting an activity that was occurring. At 11:42 AM, E10 (LPN) was observed redirecting R197 out of the Greenbank lounge and away from the activity. In an interview on 7/12/17 at 1:44 PM, E11 (Unit Clerk) confirmed that R197's screaming occurs frequently. Findings were reviewed with E2 (DON) and E3 (RN/Staff Ed) on 7/19/17 at 3 PM. The facility failed to ensure comfortable sound levels during an activity in the Greenbank lounge.	F 258	A. R5 had no untoward effect from the event and finished the activity. B. All residents have the potential to be affected by disruptive behaviors. Staff have received training for dementia care and been informed to seek assistance if a resident becomes disruptive during an activity or at any other time in the facility. C. Group activities will be structured in such a manner that limits the ability for individuals with behavioral issues to disrupt appropriate sound levels. Residents who exhibit excessive disruptive behavior will have their activities needs met with room visits, one-on-one interaction, etc. as appropriate. D. Activities Director/designee will monitor group activities daily for 14 days, weekly times 2, and monthly thereafter to ensure 100% compliance has been achieved. Results will be reported quarterly through the facility QAPI process. A. R70 had no untoward effect from the event and finished the activity. B. All residents have the potential to be affected by disruptive behaviors. Staff have received training for dementia care and been informed to seek assistance if a resident becomes disruptive during an activity or at any other time in the facility. C. Group activities will be structured in such a manner that limits the ability for individuals with behavioral issues to disrupt appropriate sound levels. Residents who exhibit excessive	

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F 258	Continued From page 11	F 258	disruptive behavior will have their activities needs met with room visits, one-on-one interaction, etc. as appropriate. D. Activities Director/designee will monitor group activities daily for 14 days, weekly times 2, and monthly thereafter to ensure 100% compliance has been achieved. Results will be reported quarterly through the facility QAPI process. A. R115 had no untoward effect from the event and finished the activity. B. All residents have the potential to be affected by disruptive behaviors. Staff have received training for dementia care and been informed to seek assistance if a resident becomes disruptive during an activity or at any other time in the facility. C. Group activities will be structured in such a manner that limits the ability for individuals with behavioral issues to disrupt appropriate sound levels. Residents who exhibit excessive disruptive behavior will have their activities needs met with room visits, one-on-one interaction, etc. as appropriate. D. Activities Director/designee will monitor group activities daily for 14 days, weekly times 2, and monthly thereafter to ensure 100% compliance has been achieved. Results will be reported quarterly through the facility QAPI process. A. R126 had no untoward effect from the event and finished the activity. B. All residents have the potential to be affected by disruptive behaviors. Staff have received training for dementia care and been informed to seek assistance if a	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 12	F 258	resident becomes disruptive during an activity or at any other time in the facility. C. Group activities will be structured in such a manner that limits the ability for individuals with behavioral issues to disrupt appropriate sound levels. Residents who exhibit excessive disruptive behavior will have their activities needs met with room visits, one-on-one interaction, etc. as appropriate. D. Activities Director/designee will monitor group activities daily for 14 days, weekly times 2, and monthly thereafter to ensure 100% compliance has been achieved. Results will be reported quarterly through the facility QAPI process. A. R143 had no untoward effect from the event and finished the activity. B. All residents have the potential to be affected by disruptive behaviors. Staff have received training for dementia care and been informed to seek assistance if a resident becomes disruptive during an activity or at any other time in the facility. C. Group activities will be structured in such a manner that limits the ability for individuals with behavioral issues to disrupt appropriate sound levels. Residents who exhibit excessive disruptive behavior will have their activities needs met with room visits, one-on-one interaction, etc. as appropriate. D. Activities Director/designee will monitor group activities daily for 14 days, weekly times 2, and monthly thereafter to ensure 100% compliance has been achieved. Results will be reported quarterly through the facility QAPI process.	

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	085004	A. BUILDING _____ B. WING _____	C 07/19/2017

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		9/4/17

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F 279	Continued From page 14 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for one (R204) out of 55 residents sampled, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility failed to identify that R204 was at risk for dehydration and they failed to care plan accordingly. Findings include: Review of R204's clinical record revealed the following: 12/29/16 - R204 was admitted to the facility with diagnoses that included dementia with behavioral	F 279	A. R204 no longer resides in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. All residents have the potential to be affected. On 1/29/17 a dietary alert form was initiated and no further events have occurred since that time. C. Resident meal consumption and fluids offered at those meals will be recorded in the resident record. Any resident consuming less than 150% (out of a total of 300% for total consumption of breakfast, lunch and dinner daily) and/or less than 500cc of fluid consumed for those meals shall have a revised dietary alert form generated for IDT review and	

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F 279	Continued From page 15 disturbance, major depression, and anxiety. 12/29/16 - The admission Nutritional Assessment stated, "...Estimated Nutritional Requirements:..Fluid (ml) 1400-1700 (amount required per 24 hours)...no nutritional problems at present...Current diet regular/thins/NAS...Resident dines independently with % meal completion 75%. Per nursing, appetite good..." 12/29/16 - The nursing admission assessment stated R204 appeared well nourished, had a good appetite, and was alert, but uncooperative and combative. 12/29/16 - A care plan for the problem "Unable to do own ADLs without assistance" stated R204 required supervision while eating and nursing was to assist the resident with meal tray and feeding if necessary. Additionally, a care plan for the problem "Resident at nutritional risk" was developed which included approaches to provide diet/meals as ordered, monitor food and fluid preferences, encourage food and fluid intake, provide assistance as needed with food/fluids, and monitor for signs of diet intolerance. 1/4/17 - The admission MDS assessment stated R204 had short and long term memory problems, was moderately impaired for daily decision making skills (decisions poor; cues/supervision required), and was exhibiting behaviors daily. Additionally, the MDS stated R204 required extensive assistance of one staff person for walking in her room and corridor, dressing, toilet use, hygiene and bathing. R204 was identified as requiring supervision and set up help for eating. Although the CAA summary did not trigger the	F 279	intervention, as needed. All licensed staff including the RDs will be in-serviced no later than September 4th. A care plan will be generated identifying at risk for dehydration following IDT recommendation. D. The unit manager/designee will review daily meal consumption percentages to ensure revised dietary alert forms have been generated accurately daily for 14 days, then weekly times 10, until 100% compliance is achieved. RNAC will ensure that a care plan is generated for those residents recommended to be at risk. Results will be reported quarterly through the facility QAPI process.	

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F 279	Continued From page 16 area of dehydration/fluid maintenance as a potential problem area, the facility failed to identify that R204 was at risk for dehydration due to her declining cognitive status and they failed to care plan accordingly. 1/5/17 3:19 PM - A nurse's progress note stated the resident had a new order to encourage fluids every shift. Review of the corresponding MAR revealed the order written as "Encourage fluids every shift for hydration for 7 days." This order did not identify how much fluid was to be encouraged, nor was there any consistent documentation as to whether R204 was accepting fluids and how much? A care plan was not developed for R204's risk for dehydration. Findings were confirmed by E1 (NHA) and E2 (DON) during an interview on 7/17/17 at approximately 4:20 PM.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews, review of the facility's pharmacy policies and the manufacturer's medication guide, it was determined that for 2 (R17 and R142) out of 55 Stage 2 sampled residents, the facility failed to provide services that met professional standards	F 281	Example 1 A. R17 no longer resides at the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled	8/28/17

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F 281	Continued From page 17 of quality. The facility failed to ensure that licensed nursing staff did not administer another resident's (R17) Vimpat medication, a controlled substance used for seizure disorders, to R142. Findings include: 8/14 - The Vimpat Medication Guide approved by the U.S. Food and Drug Administration (https://www.vimpat.com/vimpat-medication-guide.pdf) stated, "...4. VIMPAT is a federally controlled substance (C-V) because it can be abused or lead to drug dependence...Never give your VIMPAT to anyone else, because it may harm them...Take VIMPAT exactly as your healthcare provider tells you...Do not give VIMPAT to other people, even if they have the same symptoms that you have. It may harm them...". 1/1/16 - The facility pharmacy policy entitled, "Emergency Pharmacy Service and Emergency Kits" stated, "Emergency pharmacy service is available on a 24-hour basis...D. Medications are not borrowed from other residents...". 1/1/16 - The facility pharmacy policy entitled, "Medication Administration-General Guidelines", stated, "Medications are administered as prescribed in accordance with good nursing principles and practices...B. Administration...2) Medications are administered in accordance with written orders of the attending physician...12) Medications supplied for one resident are never administered to another resident...". Cross refer to F431, example 1 1. Review of R17's clinical record revealed the following:	F 281	substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. R142 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for	

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F 281	Continued From page 18 5/25/17 - A physician's order stated to administer Vimpat 200 mg tablet by mouth two times a day for a seizure disorder. 6/2/17 at 10:15 PM - A nurse's note stated that R17 was sent to the Emergency Room at 11:50 PM. 6/8/17 at 4:06 PM - A social services note stated that R17 did not retun from the hospital on 6/6/17. 6/9/17 through 6/19/17 - Review of R17's Controlled Drug Receipt/Record/Disposition Form (accountability record), issued by the pharmacy, revealed that a total of 14 tablets of R17's Vimpat 200 mg medication was signed out by one or two licensed nurses after R17 was discharged from the facility: - 6/9 at 8 PM - one tablet was signed out by two nurses and "wasted" was handwritten; - 6/10 at 9:30 AM - one tablet was signed out by one nurse and "wasted" was handwritten; - 6/10 at 8 PM - one tablet was signed out by two nurses with no reason given; - 6/11 at 8:01 AM - one tablet was signed out by one nurse and "wasted" was handwritten; - 6/11 untimed - one tablet was signed out by two nurses and "wasted" was handwritten; - 6/12 untimed - one tablet was signed out by two nurses and "wasted" was handwritten; - 6/12 untimed - one tablet was signed out by two nurses and "wasted" was handwritten; - 6/13 untimed - three tablets were signed out by two nurses and "wasted" was handwritten; - 6/17 untimed - one tablet was signed out by two nurses and "wasted" was handwritten; - 6/17 untimed - two tablets were signed out by one nurse and "wasted" was handwritten; - 6/19 untimed - one tablet was signed out by one	F 281	actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	

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F 281	Continued From page 19 nurse and "wasted" and R142's room number were handwritten. Cross refer to F431, example 4 2. Review of R142's clinical record revealed the following: 6/16/17 - A physician's order stated to administer Vimpat 100 mg tablet one time only for one day; then Vimpat 150 mg tablet two times a day for two days; then Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R142's June 2017 eMAR revealed the following: - Saturday, 6/17/17, AM - E14 (LPN) signed off that R142 received Vimpat 150 mg tablet; - Sunday, 6/18/17, AM - E14 signed off that R142 received Vimpat 150 mg tablet; - Monday, 6/19/17, AM - E21 (LPN) signed off that R142 received Vimpat 200 mg tablet. Review of R142's clinical record revealed the absence of the accountability record for his Vimpat 150 mg medication. While R142's clinical record revealed the absence of the accountability record for his 6/19/17 AM Vimpat 200 mg dose, it was identified that the medication was taken from R17, a discharged resident, on 6/19/17 and recorded on R17's accountability record. On 7/18/17 at 10:54 AM, surveyor met with E2 (DON) and E3 (RN/Staff Ed) to find out why 14 tablets of R17's Vimpat medication were signed off as "wasted" on her Controlled Drug Receipt/Record/Disposition Form after R17 was discharged from the facility. E2 and E3 stated	F 281		

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F 281	Continued From page 20 they would look into it and follow-up with surveyor. During a follow-up interview with E2 and E3 on 7/18/17 at 1:50 PM, E2 stated that Vimpat medication was not included in the facility's backup medication stock. E3 stated that licensed nursing staff used R17's Vimpat medication and administered her medication to other residents, including R142. During an interview on 7/19/17 at 9:35 AM, E14 (LPN) stated that R142 did not have Vimpat 150 mg tablet medication readily available to be administered the morning of 6/17/17. E14 stated that she called the pharmacy regarding R142's Vimpat medication. E14 stated that she performed an electronic computer search of all residents in the facility that were on Vimpat medication. E14 stated that she asked E9 (LPN), another nurse assigned to a different medication cart, for Vimpat medication. E14 stated that E9 gave her Vimpat 200 mg tablet from another resident (R17). E14 stated that she altered R17's Vimpat 200 mg tablet by cutting the unscored tablet and administered the altered medication to R142. When asked if she notified the House Supervisor regarding the absence of R142's seizure medication availability over the weekend, E14 stated "no". During an interview on 7/19/17 at 9:52 AM, E9 stated that E14 asked her for Vimpat medication. E9 stated that she removed, signed off as "wasted" on R17's Vimpat accountability record and gave two tablets (200 mg each) of R17's Vimpat medication to E14 for R142. E9 confirmed her signature on R17's accountability record for 2 tablets of Vimpat on 6/17/17.	F 281		

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F 281	Continued From page 21 Findings were reviewed on 7/19/17 at 3 PM with E2 and E3. The facility failed to provide services that met professional standards by ensuring that licensed nursing staff did not administer another resident's (R17) Vimpat medication, a controlled substance used for seizure disorders, to another resident, R142. Additionally staff provided incorrect information on the accountability record.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		8/28/17

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F 309	Continued From page 22 and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record reviews, interviews and review of facility documentation, it was determined that for 2 (R2, R143) out of 55 Stage 2 sampled residents, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being consistent with professional standards of practice and their comprehensive person-centered care plans. For R2, the facility failed to follow her plan of care when it was observed that R2's disposable underpad was pulled up tight between her legs two different times when the disposable underpads were to lay flat underneath her. For R143, the facility failed to follow the physician's order to administer prn Ativan, medication for anxiety, every 6 hours on 7/1/17. Findings include: 1. Review of R2's clinical record revealed the following: Last reviewed on 5/3/17, R2 was care planned for: - semi-comatose state; - incontinent of bladder and bowel with interventions that included to provide incontinence care every 2 hours and as needed...use pads or briefs;	F 309	Example 1 A. R2 continues to reside in the facility and suffered no untoward effect. B. All residents utilizing Chux for incontinence care have the potential to be affected. C. Clinical staff will be re-educated on the proper placement of Chux no later than August 28th. D. Staff developer/designee will audit a representative sample of residents utilizing Chux to ensure compliance daily for 14 days and weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. R143 suffered no untoward effect and continues to reside in the facility. B. Any resident receiving PRN Ativan has the potential to be affected. C. All licensed staff will be re-educated regarding appropriate Medication administration to include the "5Rs" by August 28th. D. The unit manager/designee will review a representative sample in the MAR daily x 14 days, weekly times 10 until 100%	

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F 309	Continued From page 23 - potential for alteration in skin integrity due to decreased mobility and bladder/bowel incontinence with an intervention that included to keep bed linens wrinkle free. Review of R2's Resident Care Profile for the CNAs to reference, last updated on 5/3/17, revealed the absence of special instructions for incontinence care to meet R2's needs. On 7/17/17 at 5:35 AM, E15 (CNA) with E19 (CNA orientee) were observed providing incontinence care to R2. R2 was observed with 2 disposable underpads under her with one disposable underpad pulled up tight between her legs covering her genital area. The disposable underpad was soiled with a bowel movement. E15 was observed cleaning R2 and then placing another clean disposable underpad under R2 and pulling the underpad up tight between R2's legs covering her genital area. During this time, the surveyor observed a sign on R2's wall above her bed that stated, "No attends. No pads. Chuck (sic) (Chux) and draw sheet only!!!!" During an interview on 7/17/17 at 7:30 AM, E18 (RNAC) and this surveyor discussed what was observed and reviewed R2's care plan. It was unclear why R2's incontinence care plan, last reviewed on 5/3/17, stated to use pads or briefs, which contradicted the sign posted on R2's wall. The facility failed to follow R2's care plan and her Resident Care Profile. During an interview on 7/17/17 at 8:28 AM, E20 (CNA) confirmed that R2 does not wear attends or pads. E20 demonstrated and stated that a disposable underpad is placed under R2 and must lay flat across the width of the bed to	F 309	compliance is achieved. Results will be reported quarterly through the facility QAPI process.	

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F 309	Continued From page 24 prevent skin breakdown. E20 confirmed that R2's disposable underpad should not be pulled up tight between her legs covering her genital area. Findings were reviewed with E2 (DON) and E3 (RN/Staff Ed) on 7/19/17 at 3 PM. The facility failed to provide treatment and care in accordance with R2's plan of care to meet her needs. 2.. Review of R143's clinical record revealed the following: R143 was admitted to the facility on 3/30/15 with a diagnosis that included anxiety. 1/31/17 - A physician's order stated to give prn Ativan medication every 6 hours for anxiety. Review of R143's July 2017 eMAR revealed that two doses of Ativan were administered on 7/1/17 at 2:52 PM and 7:11 PM, with approximately 4.25 hours between administrations. Findings were reviewed with E13 (RN/Unit Manager) on 7/19/17 at 1 PM. The facility failed to follow the physician's order to administer prn Ativan every 6 hours for anxiety.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		9/4/17

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F 312	Continued From page 25 Based on observations, record review and interviews, it was determined that the facility failed to provide the necessary services to maintain good grooming and personal hygiene for one (R72) resident, who was unable to carry out activities of daily living, out of 55 Stage 2 sampled residents. Findings include: A quarterly MDS assessment, dated 6/23/17, stated R72 required extensive assistance of one staff for dressing and was totally dependent on one staff for toilet use, hygiene and bathing. The MDS stated R72 had weakness of one entire side of the body and was incontinent of bowel and bladder. A. R72 had a care plan, last reviewed 7/12/17, for the problem "Unable to do own ADLs without assistance." Approaches included to assist the resident with dressing and hygiene care to the extent required. Observations on 7/11/17 at 3:00 PM, 7/14/17 at 9:40 AM and 7/14/17 at 1:40 PM revealed R72 with elongated jagged fingernails, especially both thumbs, in need of trimming. On 7/14/17 at 1:40 PM, E22 (LPN, Brandywine UM) observed R72's fingernails at the surveyor's request and confirmed they were in need of trimming. B. R72 had a care plan, last reviewed 7/12/17, for the problem "Incontinent of bladder and bowel." Approaches included incontinence care every 2 hours and as needed and skin check every 2 hours and as needed with incontinence care. On 7/17/17 at 6:30 AM, E6 (CNA) was observed	F 312	Example A A. R72 continues to reside in the facility and the fingernails were trimmed during the survey. B. All residents who require assistance with ADLs have the potential to be affected. C. All direct care staff will be re-educated regarding ADL care for those needing assistance by August 28th. D. The staff developer/designee will observe a representative sample of residents requiring ADL assistance, including nail care, daily for 14 days and weekly times 10, until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example B A. R72 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice were disciplined for failing to follow appropriate policy and procedure. resident will continue with Q2H check and change. B. All residents who require assistance with ADLs have the potential to be affected. C. Clinical staff will be re-educated on the proper placement of Chux and incontinence care for dependent residents to include those residents that require Q2H check and change no later than September 4th. D. The staff developer/designee will audit a representative sample of residents utilizing Chux and those requiring Q2H	

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F 312	Continued From page 26 providing morning care for R72. Observation revealed R72's brief, three (3) Chux, a draw sheet and the mattress cover soaked through with urine. When asked what time R72 was last changed, E6 stated "at approximately 2:15 AM." At approximately 7:15 AM, E6 was asked why R72 was not changed for over 4 hours? E6 stated, "That's my fault." The facility failed to ensure that R72, a dependent resident, was provided necessary services according to the care plan, which stated incontinence care was to be provided every 2 hours and as needed. Findings were confirmed with E1 (NHA) and E2 (DON) during an interview on 7/17/17 at approximately 4:15 PM.	F 312	check and change to ensure compliance daily for 14 days and weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		9/4/17

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F 323	Continued From page 27 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to ensure that the resident environment remains as free from accident hazards as is possible, and that assistance devices are utilized to prevent accidents for one (R72) out of 55 Stage 2 sampled residents. Findings include: 1. A quarterly MDS assessment, dated 6/23/17, stated R72 did not walk in his room or the corridor, and was totally dependent on two (2) staff for transfers to and from bed. A care plan, last reviewed 7/12/17, for the problem "Potential for injury," included the approach for R72 to be transferred by 2 staff with a Hoyer lift. On 7/17/17 at approximately 6:50 AM, E6 (CNA) and E7 (CNA) were observed transferring R72 from bed to his chair. E6 sat R72 up at the edge of his bed and then E6 and E7 manually lifted and pivoted the resident into his chair. A Hoyer lift was not utilized for the transfer as per the care plan resulting in potential accident hazard and injury to R72. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/17/17 at approximately 4:15 PM.	F 323	Example 1 A. R72 continues to reside in the facility and had no untoward effect. B. All residents who require assistance with transfers with assistive devices have the potential to be affected. C. All clinical staff will be re-educated on the identification of resident transfer status and proper use of the required transfer (e.g. Hoyer) device by September 4th. D. The unit manager/designee will audit a representative sample of residents requiring transfer with assistive devices daily for 14 days, weekly times 10 and then monthly times two until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. The side rail for Room B16 C bed has been secured. B. All residents with side rails have the potential to be affected. C. All care giving staff will be in-serviced regarding the proper reporting of loose side rails. D. The unit manager/supervisor will	

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F 323	Continued From page 28 2. On 7/11/17 at 3 PM during Stage 1 and on 7/12/17 at approximately 12:48 PM, it was observed that the left side rail for Room B16 C bed was loose. All issues were reviewed and confirmed by E4 (Maintenance Director) and E5 (Housekeeping Director) on 7/14/17 at approximately 11:00 AM.	F 323	observe side rails on two beds on each hallway (6) to ensure they are secure daily for 14 days, then weekly for two weeks, then monthly until 100% compliance is observed. Results will be reported quarterly through the facility QAPI process.	
F 327 SS=G	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that one (R204) out of 55 residents sampled was offered sufficient fluid intake to maintain proper hydration and health. The facility failed to identify R204 as being at risk for dehydration, failed to care plan accordingly and failed to consistently monitor and evaluate R204's fluid consumption. When R204's meal and fluid intakes steadily declined there was no notification of the physician and/or RD and no new interventions implemented until 1/17/17. On 1/17/17, R204 became unresponsive and was sent out to the ER where she was found to be severely dehydrated with an	F 327	A. R204 no longer resides in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. All residents have the potential to be affected. On 1/29/17 a dietary alert form was initiated and no further events have occurred since that time. C. Resident meal consumption and fluids offered at those meals will be recorded in the resident record. Any resident consuming less than 150% (out of a total of 300% for total consumption of breakfast, lunch and dinner daily) and/or	9/4/17

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F 327	Continued From page 29 acute kidney injury (AKI). This deficient practice resulted in harm to R204. Findings include: Review of R204's clinical record revealed the following: 12/29/16 - R204 was admitted to the facility with diagnoses that included dementia with behavioral disturbance, major depression, and anxiety. 12/29/16 - The admission Nutritional Assessment stated, "...Weight: 141.0...Estimated Nutritional Requirements:..Fluid (ml) 1400-1700 (amount required per 24 hours)...no nutritional problems at present. Assessment/Plan: New admit:..reweight: 141 lbs...Current diet regular/thins/NAS...Resident dines independently with % meal completion 75%. Per nursing, appetite good...Resident added to weekly weights and will monitor nutritional parameters." 12/29/16 - The nursing admission assessment stated R204 appeared well nourished, had a good appetite, and was alert, but uncooperative and combative. 12/29/16 - A care plan for the problem "Unable to do own ADLs without assistance" stated R204 required supervision while eating and nursing was to assist the resident with her meal tray and feeding if necessary. Additionally, a care plan for the problem "Resident at nutritional risk" was developed which included approaches to provide diet/meals as ordered, monitor food and fluid preferences, encourage food and fluid intake, provide assistance as needed with food/fluids, and monitor for signs of diet intolerance. A care plan was not developed for the potential for dehydration.	F 327	less than 500cc of fluid consumed for those meals shall have a revised dietary alert form generated for IDT review daily at morning meeting. All licensed staff including the RDs will be in-serviced no later than September 4th. D. The unit manager/designee will review daily meal consumption percentages to ensure revised dietary alert forms have been generated accurately daily for 14 days, then weekly times 10, until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	

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F 327	Continued From page 30 12/30/16 - The facility completed a "Functional Abilities Review," completed by the SLP, which stated R204 was tolerating the current diet texture with no signs of choking or difficulty swallowing. The review stated that speech therapy services were not warranted at this time. 12/30/16 3:41 PM - A Psychological Initial Assessment stated, "...severe dementia with behavioral disturbances...Resident has been hitting staff and yelling. Has needed medication to attempt to decrease behaviors...Staff encouraged to anticipate residents needs (toileting, addressing hunger/thirst) to avoid behavioral disruption." 12/30/16 - R204's re-weight recorded as 141.0 lbs. 1/1/17 - A physician's order was written for R204 to receive Zyprexa 2.5 mg three times a day for behaviors. 1/3/17 - Laboratory blood test results revealed the following values: Sodium = 146 (normal range: 135-145); BUN = 22 (normal range: 10-26); Creatinine = 0.7 (normal range: 0.5 - 1.5). 1/3/17 5:05 PM - A nurse's progress note stated that medication given for constipation was held due to R204 having loose bowel movements. A second note, timed 11:26 PM, stated the resident was "extremely agitated...oral mucosa pink and moist, appetite fair, fluids encouraged...". 1/4/17 - Laboratory blood test results revealed the following values:	F 327		

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F 327	Continued From page 31 Sodium = 147; BUN = 23; Creatinine = 0.6. 1/4/17 - The admission MDS assessment stated R204 had short and long term memory problems, was moderately impaired for daily decision making skills (decisions poor; cues/supervision required), and was exhibiting behaviors daily. Additionally, the MDS stated R204 required extensive assistance of one staff person for walking in her room and corridor, dressing, toilet use, hygiene and bathing. R204 was identified as requiring supervision and set up help for eating. 1/4/17 12:34 PM - A nurse's progress note stated while sitting up in a wheelchair at the nurse's station, R204 appeared to be unresponsive. R204 was taken back to her room where she responded to painful stimuli, became alert but was still not responding appropriately. The physician was called and ordered R204 be sent to the ER for evaluation. 1/5/17 3:52 AM - A nurse's progress note stated R204 returned from the ER at 1:30 AM and was alert and responsive. 1/5/17 - A physician's order was written to decrease the Zyprexa 2.5 mg from three times a day to twice a day. 1/5/17 12:38 PM - A nutrition/dietary note stated R204's weights were being monitored weekly, however, nursing reported they were unable to complete R204's weight that morning due to her being lethargic. There was no evidence the facility attempted to obtain a weight until the following week.	F 327		

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F 327	Continued From page 32 1/5/17 12:43 PM - A nurse's progress note stated, "Resident alert and responsive...appetite fair...assistance w/lunch...sitting quietly at nurse's station." 1/5/17 3:19 PM - A nurse's progress note stated the resident had a new order to encourage fluids every shift. Review of the corresponding MAR revealed the order written as "Encourage fluids every shift for hydration for 7 days." This order did not identify how much fluid was to be encouraged, nor was there any consistent documentation as to whether R204 was accepting adequate fluids. 1/5/17 8:28 PM - A nurse's progress note stated the medication used for constipation was held due to R204 having loose bowel movements. 1/5/17 11:31 PM - A nurse's progress note stated R204 was exhibiting frequent episodes of agitation especially during care, but that her appetite was good and fluids adequate. 1/6/17 11:46 PM - A nurse's progress note stated, "...appetite fair, fluids adequate...". 1/8/17 10:04 PM - A nurse's progress note stated, "...Decreased appetite during breakfast dinner and lunch...Husband visited...complained about her mental status...". A second note timed 10:20 PM stated, "Late Entry 1/8/17 Did attempt to offer alternatives and ensure (liquid dietary supplement) due to decreased appetite in presence of husband. gave alternatives to husband, but attempts were ineffective as resident continue (sic) to refuse and become combative." Despite this documented decline in	F 327		

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F 327	Continued From page 33 intakes there was no evidence that the physician and/or RD were notified. 1/5/17 through 1/11/17 - Review of the MAR revealed nursing staff were signing each shift that fluids were encouraged. However, there was no documented evidence of how much fluid was consumed or whether it was accepted. 1/5/17 through 1/11/17 - Review of the CNA ADL Flowsheet of "percentage of meal consumption" revealed the following for intake of solids: 1/5/17 - breakfast 75%; lunch 25%; dinner 75%; 1/6/17 - breakfast 25%; lunch 25%; dinner 50%; 1/7/17 - breakfast 25%; lunch 25%; dinner 25%; 1/8/17 - breakfast 50%; lunch 50%; dinner 25%; 1/9/17 - breakfast 50%; lunch 75%; dinner 75%; 1/10/17 - breakfast 50%; lunch 25%; dinner 75%; 1/11/17 - breakfast refused; lunch refused; dinner no % documented. Review of the clinical record lacked evidence that the physician and/or RD were notified regarding R204's fluctuating food intakes. Additionally, review of the CNA ADL flowsheet revealed that from 1/1/17 through 1/10/17, R204 was feeding herself or requiring supervision or verbal cuing only. However, starting 1/12/17 documentation revealed R204 was requiring more assistance eating, with multiple occasions noting she was totally dependent for eating. Review of R204's meal time fluid intakes (for all 3 meals) from 1/2/17 through 1/11/17 revealed the following total amounts: 1/2/17 - 720 mls; 1/3/17 - 360 mls; 1/4/17 - 120 mls; 1/5/17 - 480 mls; 1/6/17 - 360 mls;	F 327		

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F 327	Continued From page 34 1/7/17 - 360 mls; 1/8/17 - 240 mls; 1/9/17 - 720 mls; 1/10/17 - 720 mls; 1/11/17 - refused breakfast and lunch and no intake documented for dinner. Review of the above listed totals revealed that unless R204 was being provided additional fluids (e.g. during medication administration or between meals) ranging in amounts from 680 mls to 1280 mls, depending on the amount of fluids consumed at each meal, she was not meeting her daily fluid requirement of 1400-1700 mls to maintain good hydration and health. Although nursing staff were documenting on the MAR from 1/5/17 through 1/11/17 that fluids were encouraged there was no documented evidence that R204 was actually consuming the fluids. Review of the clinical record lacked evidence that the facility monitored and evaluated R204's fluid intakes; no evidence that they identified that her fluid needs were not being met, and no evidence that the physician and/or RD were notified in an attempt to implement new interventions. Review of the clinical record revealed that the 1/5/17 physician's order to encourage fluids for 7 days was not renewed on 1/12/17. 1/13/17 - R204's weight recorded as 140.2. 1/14/17 8:46 AM - A nurse's progress note stated, "Resident alert and responsive...appetite fair...mucous membranes pink and moist...". 1/15/17 7:30 PM - A nurse's progress note stated that R204 was given a Phenergan suppository for nausea and vomiting and that it was effective.	F 327		

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F 327	Continued From page 35 1/16/17 1:22 PM - A nurse's progress note stated, "Resident has a new order to begin mechanical soft diet per family request." 1/16/17 - A PT Evaluation & Plan of Treatment was completed. The evaluation stated, "...Reason for Referral: Received a nursing referral due to decline in function, unsteady gait and frequent falls. According to nursing, patient was previously ambulatory without assistive device upon admission to this facility, and is currently in a WC...Clinical Reasoning...difficulty participating in functional activities due to lethargy and behavioral disturbance, unable to ambulate...". Review of R204's meal intake records from 1/12/17 through 1/16/17 revealed the following amounts: 1/12/17 - breakfast and lunch refused; dinner 75%; 1/13/17 - breakfast and lunch 50%; dinner 25%; 1/14/17 - breakfast and lunch 50%; dinner 25%; 1/15/17 - breakfast and lunch 25%; dinner 0%; 1/16/17 - breakfast and lunch 25%; dinner 0%. Review of R204's meal time fluid intakes (for all 3 meals) from 1/12/17 through 1/16/17 revealed the following total amounts: 1/12/17 - 360 mls; 1/13/17 - 480 mls; 1/14/17 - 360 mls; 1/15/17 - 120 mls; 1/16/17 - 240 mls. There was no evidence that staff were encouraging or that the resident was consuming additional fluids in an attempt to meet her estimated minimum fluid requirement of 1400 mls per 24 hours. The clinical record lacked evidence	F 327		

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F 327	Continued From page 36 that the facility monitored and/or evaluated R204's fluid intakes, that the facility identified her fluid needs were not being met, and that the physician and/or RD were notified in a timely manner in an attempt to implement new interventions. There was no evidence that the RD was notified of R204's declining intakes until 1/17/17. 1/17/17 10:52 AM - A nutrition/dietary note stated, "Per nursing report Resident experiencing decreased appetite. % (percent) meal completion ranging between 0-50%...added 8 oz ensure enlive PO BID...Added 30 ml Promod BID...Reviewed labs: Na 147 slightly elevated (results from 1/4/17). Wrote dietary slip to kitchen to send extra fluids on meal trays. Will continue to monitor weekly weights, encourage po food/fluids, and nutritional parameters." 1/17/17 11:01 AM - A nutrition/dietary note stated, "Addendum: Diet: mech (mechanical) soft/thins/NAS. Diet liberalized and NAS d/ced to increase palatability of meals." 1/17/17 11:09 AM - A nurse's progress note stated, "Resident has a new order for STAT CBC and BMP, UA C&S and Chest X ray due to change in mental status, dark foul smelling urine and cough...". 1/17/17 2:55 PM - A nurse's progress note stated, "Resident alert to her name...appetite poor...". 1/17/17 - Review of laboratory blood and urine reports revealed results were faxed to the facility on 1/17/17 at approximately 5:15 PM. Results were as follows: BUN = 163 (normal range: 10-26);	F 327		

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F 327	Continued From page 37 Sodium = 165 (normal range: 135-145); Creatinine = 5.2 (normal range: 0.5 - 1.5); UA = negative; Additionally, the chest X ray results did not identify any pneumonia or fluid in the lungs. 1/18/17 1:25 AM - A nurse's progress note stated, "Resident was resting in chair with eyes closed at start of shift, attempt was made to arouse resident, change in mental status observed, unable to speak, unable to take in fluids...sent to (hospital) via 911 at 1730 (5:30 PM)...". 1/20/17 1:28 AM - Late entry for 1/15/17 3-11 shift, Resident vomited a small amount of undigested soup while eating dinner, warm ginger ale offered and accepted, Phenergan suppository administered, no further episode of nausea or vomiting throughout shift...loose BM at the end of the shift, fluids offered and accepted...". The facility failed to identify that R204 was not meeting her minimum fluid requirement and they failed to implement interventions in an attempt to meet this fluid requirement. There was no evidence that R204's oral intake was being monitored consistently and that decreased food and fluid intakes were reported to the physician and/or RD in a timely manner. R204 was sent out to the ER when she became unresponsive and was diagnosed with severe dehydration and acute kidney injury. R204 was admitted to the hospital on 1/17/17. The hospital ED Physician Record, dated 1/17/17 and timed 6:04 PM stated, "...found unresponsive in her nursing home...she has been slightly lethargic for the last several days. Somnolent.	F 327		

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F 327	Continued From page 38 She has not been taking much oral intake including food or water. She does have some mild nausea and vomiting over the weekend...severely dry mucous membranes with dry tongue...Initial laboratory results revealed significant hyponatremia (sic/should read hypernatremia) with sodium 171. Acute renal failure with BUN of 156 creatinine 6.2...She received approximately 2L (liters) of IV fluids...sodium improving to 170...improving creatinine of 5.6...". A second hospital ED Physician Record, dated 1/17/17 and timed 6:09 PM stated, "...As per the family she has not been doing well for the past 3 weeks since her admission to the nursing home...family states she has not been eating or drinking since her admission, but significantly less over the past 1 week..The family states that over the past 2-3 days she has been much more altered than her baseline mental status...dry oral mucosa...After approximately 15 minutes of being in the emergency department the patient is much more awake and alert and is able to tell me her name...2L of NS (Normal Saline) was given for hypernatremia likely 2/2 (secondary to) dehydration. The patient's mental status continues to improve while in the ER...". A hospital nephrologist's consult note, dated 1/18/17, stated, "...progressive Alzheimer's dementia, presenting to the ED yesterday evening unresponsive...recently transferred to a nursing home...Over the past few days, she reportedly became increasingly lethargic...Upon arrival to (hospital name) ED was tachycardic (rapid heart rate), unresponsive, with elevated creatinine...hypernatremia...On previous visits when tested her renal function was normal with	F 327		

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F 327	Continued From page 39 baseline creatinine 0.8...oral mucosa dry...Assessment/Plan: 1. Acute kidney injury: This is clearly acute, with normal baseline creatinine just earlier this month. Most likely due to volume depletion...2. Hypernatremia: Severe at presentation sodium 171...Attributable to poor oral intake over some time...Additional Recommendations or Comments:...5. Long-term she will require some means of reliably maintaining adequate oral/fluid intake...". 7/17/17 approximately 4:00 PM - During an interview with E16 (RD) and E17 (RD), E17 stated that when she noted on 1/5/17 the order to encourage fluids, she sent a request slip to dietary to send extra fluids on the meal trays. E17 stated she was not notified that R204 was not eating well until 1/17/17 at which time she ordered supplements. After R204's meal and fluid intakes were reviewed, E17 confirmed she should have been notified sooner. 7/17/17 at approximately 4:20 PM - During an interview with E1 (NHA) and E2 (DON) regarding the facility's failure to identify R204's risk for dehydration and subsequent care planning, the facility's lack of monitoring of fluid intakes and lack of identifying that minimum fluid needs were not being met and resulting in severe dehydration, the findings were confirmed.	F 327		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		8/28/17

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F 329	Continued From page 40 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interview, it was determined that for 2 (R197 and R143) out of 55 Stage 2 sampled residents, the facility failed to provide adequate indications for use and non-pharmacological interventions [such as	F 329	Example 1 A. R197 experienced no untoward effect and continues to reside in the facility. B. All residents with PRN anti-anxiety medications have the potential to be	

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F 329	Continued From page 41 redirect, 1 on 1, activity, food/fluids, toilet, reposition] prior to administering prn psychotropic medications. Findings include: 1. Review of R197's clinical record revealed the following: 3/10/17 - A physician's order stated to administer Ativan (a psychotropic medication) every 8 hours prn for anxiety/agitation. 3/10/17 - A physician's order stated to document R197's behaviors and non-pharmacological interventions (redirect, 1 on 1, activity, food/fluids, toilet, reposition) used for psychotropic medication use every shift in the progress notes. R197's progress notes lacked evidence of her behaviors and non-pharmacological interventions used prior to the prn Ativan administrations on the following dates and times: - 3/13/17 at 6:35 PM; - 3/15/17 at 2:01 PM; - 3/20/17 at 5:53 PM; - 3/21/17 at 9:33 PM; - 4/3/17 at 7:30 PM; - 4/19/17 at 6:58 PM; - 6/14/17 at 1:18 PM; - 6/26/17 at 3:21 PM; - 7/10/17 at 3:23 PM. 2. Review of R143's clinical record revealed the following: 2/11/16 - A physician's order stated to document R143's behaviors and non-pharmacological interventions used for psychotropic use every shift in the progress notes.	F 329	affected. C. Staff will be re-educated regarding the standard of care related to non-pharmacologic interventions and the documentation thereof prior to administration of prn anti-anxiety medications by August 28th. D. DON/designee will audit representative sample of those residents receiving prn anti-anxiety medications to ensure appropriate non-pharmacological interventions were offered prior to medication administration daily for 14 days, weekly times 10 until 100% compliance is observed. Results will be reported quarterly through the facility QAPI process. Example 2 A. R143 experienced no untoward effect and continues to reside in the facility. B. All residents with PRN anti-anxiety medications have the potential to be affected. C. Staff will be re-educated regarding the standard of care related to non-pharmacologic interventions and the documentation thereof prior to administration of prn anti-anxiety medications by August 28th. D. DON/designee will audit representative sample of those residents receiving prn anti-anxiety medications to ensure appropriate non-pharmacological interventions were offered prior to medication administration daily for 14 days, weekly times 10 until 100% compliance is observed. Results will be reported quarterly through the facility	

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F 329	Continued From page 42 1/31/17 - A physician's order stated to administer Ativan every 6 hours prn for anxiety. R143's progress notes lacked evidence of her behaviors and non-pharmacological interventions used prior to the prn Ativan administrations on the following dates and times: - 7/1/17 at 2:52 PM; - 7/4/17 at 4:57 PM; - 7/8/17 at 2:10 PM; - 7/10/17 at 6:48 PM. During an interview on 7/19/17 at 1 PM, E13 (RN) acknowledged that non-pharmacological interventions should be used prior to the administration of prn psychotropic medications. Findings for R197 and R143 were immediately reviewed with E13. Findings were reviewed with E2 (DON) and E3 (RN/Staff Ed) on 7/19/17 at 3 PM. The facility failed to provide adequate indications for use and non-pharmacological interventions prior to administering prn psychoactive medications.	F 329	QAPI process.	
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and review of other facility documents it was determined that the facility failed to ensure that 6	F 333	Example 1A A. R196 continues to reside at the facility and be monitored per physician order.	9/11/17

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F 333	Continued From page 43 (R40, R71, R91, R117, R181, and R196) out of 55 Stage 2 sampled residents were free of significant medication errors. Thirteen (13) Units of Humalog insulin was administered to R196 when the blood sugar value was 88 causing R196's blood sugar level to drop to 21 resulting in the resident becoming unresponsive and requiring emergency interventions. Additionally, there was no documented evidence that R196 was receiving and/or consuming bedtime snacks. The facility failed to ensure for R71 and R181 that Humalog insulin was administered according to manufacturers specifications, specifically within 15 minutes before a meal or immediately after a meal. For R40, R91, and R117, the facility failed to ensure that Novolog insulin was administered according to manufacturers specifications, specifically within 5-10 minutes before a meal. Findings include: The manufacturer's package insert (http://uspl.lilly.com/humalog/humalog.html) for Humalog insulin stated, "...INDICATIONS AND USAGE: HUMALOG is a rapid acting human insulin...DOSAGE AND ADMINISTRATION:...Administer HUMALOG...within 15 minutes before a meal or immediately after a meal..." The manufacturer's package insert (http://www.novo-pi.com/novolog.pdf) for Novolog insulin stated, "...INDICATIONS AND USAGE: NOVOLOG is rapid acting human insulin...DOSAGE AND ADMINISTRATION:...Inject...within 5-10 minutes before a meal..." 1A. Review of R196's clinical record revealed the following:	F 333	Agency nurse statement was obtained. Agency nurse was subsequently removed from the building and has been prohibited from providing care at Brandywine. Appropriate notification to DLTCRP was also made. B. All residents requiring short acting insulin have the potential to be affected. C. All licensed staff, including on-coming agency nurses, will be in serviced regarding appropriate use of short acting insulin. D. Staff developer/designee will review all residents with short acting insulin for adequate appropriate insulin administration per facility policy daily for 14 days, weekly times 10, until 100% compliance is observed. Documentation that all licensed staff received this in-service will be presented to the QA committee at least quarterly. Example 1B A. R 196 was immediately treated by staff using IV fluids and D50%. Resident stabilized and remained in the facility. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised	

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F 333	Continued From page 44 4/14/17 - R196 was admitted to the facility with diagnoses that included diabetes mellitus which required the administration of insulin for blood sugar control. 4/14/17 - A physician's order was written for R196 to have Humalog SSI coverage dependant on Accu-Chek results that were to be completed before meals. The order stated that when R196's Accu-Chek result was 0 to 199, no SSI coverage was to be given. 4/19/17 - R196's progress notes stated: 7:00 AM - "Orders-Administration Note: May initiate I.V. access in potentially critical situations as needed. Then notify physician for further orders." 7:30 AM - "...I was called to pt's bedside due to AMS and low BG of 21 at approximately 0730. Nurse in charge of pt at that time stated to me that she gave pt 13 units of insulin when her BG was 88." This progress note was completed by the PA. 7:55 AM - "This nurse went in to resident room to do rounds and saw resident unresponsive. Upon assessment, resident BS is 21, Glucagon 1 amp IM was administered and after 30 mins BS was 23, (name of PA) was in the building gave a verbal order for another glucagon 1 amp IM to be administered 911 was called. At 0801 resident became responsive with BS at 224. Resident decline (sic) to go to the hospital and is eating her breakfast in her room at this time." 4/19/17 10:02 AM - A physician's medical visit note stated, "...BS this am 88 but apparently given extra dose 13 units and BS dropped to 21 glucagon administered; BS 200s pt denies any	F 333	procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. Example 1C A. R196 continues to reside at the facility and continues to be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All diabetic residents will be offered a substantial HS snack; percent consumed will be documented in the medical record. All clinical staff will be in-serviced regarding appropriate presentation and documentation of HS snack or supplement consumed. D. Staff developer/designee will review all diabetic residents for HS snack compliance daily for 14 days, weekly times 10, until 100% compliance is observed. Results will be reported quarterly through the facility QAPI process. Example 2 A. R71 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting	

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F 333	Continued From page 45 complaints now." Review of the facility's incident investigation revealed the following statements: 4/19/17 (Completed by E12 (Agency LPN)) - "Blood sugar was checked by this nurse at about 0630 a.m. Resident is on a sliding scale of insulin, blood sugar protocol was followed as order (sic). At about 0708 Unit Manager was doing her rounds and discovered pt being hypoglacemic (sic). Followed the order/care as 13 unit (sic) of insulin was administered." While the Agency LPN wrote in her statement that blood sugar protocol was followed this was not correct since insulin was administered for a blood sugar of 88. 4/19/17 (Completed by E13 (Greenbank UM)) - "I responded to a page overhead. Resident observed unresponsive. BS was in the 20's. I started an IV in the right arm. EMS arrived as soon as I finished and they took over." 4/19/17 (Completed by E3 (Staff Education RN)) - "This nurse was overhead paged...Upon arriving in room noted resident in bed not responding to nurse manager. Resident had a BS of 21...I contacted PA who was in facility who gave me order to call 911. Myself & PA (name) asked nurse how much Novolog they administered and nurse went to check & returned and stated 13 units. This nurse asked nurse again did you administer 13 units of Novolog to a resident who had a BS of 88 and nurse stated 'Yes she did.' I asked the nurse again if she was sure & she stated 'Yes.' " 4/19/17 12:45 PM - The facility's Incident Report submitted to the State Agency stated, "Agency Nurse administered 13 units of insulin for...88. Resident found unresponsive. According to	F 333	insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. Example 3 A. R40 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure.	

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F 333	Continued From page 46 agency nurse insulin was administered at 0630 and resident was found...at approximately 0700. IV access initiated and PA in building and made aware. Paramedics arrived and administered D50. Resident became AAO3 and refused hospitalization...resident currently in no acute distress. Agency nurse banned from building. Agency and MD aware." The facility failed to ensure that R196 was free of a significant medication error. R196 was given Humalog insulin 13 units when no insulin coverage was required. R196 became unresponsive with a severely low BS requiring the administration of 2 amps of Glucagon, insertion of an IV and administration of D50. This deficient practice resulted in harm to R196. On 7/18/17 at approximately 4:15 PM, findings were reviewed with E1 (NHA) and E2 (DON). E1 and E2 acknowledged the findings and stated that E12 has been banned from working in the facility. 1B. R196 had a physician's order, dated 4/14/17, for Humalog SSI coverage before meals. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to the B wing (where R196 resided) at 8:10 AM. Review of the July 2017 MAR revealed that Accu-Cheks were completed by the night shift (11 PM - 7:30 AM) and signed off at 6:30 AM. Although the Accu-Cheks may have been completed closer to 7:30 AM and SSI coverage given at that time, there was still a delay of approximately 40 minutes before breakfast was served. R196 was receiving Humalog, a fast	F 333	D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. Example 4 A. R181 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. Example 5 A. R117 suffered no untoward effect or	

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F 333	Continued From page 47 acting insulin, which is to be given within 15 minutes before a meal or immediately after a meal. Review of the MAR from 4/14/17 through 5/18/17 revealed that R196 received SSI coverage, signed off at 6:30 AM, on the following dates: 4/17/17, 4/18/17, 4/19/17, 4/20/17, 4/26/17, 4/30/17, 5/1/17, 5/9/17, 5/10/17, 5/14/17 and 5/16/17. R196 had a physician's order, dated 5/16/17, to receive Basaglar KwikPen insulin 6 units daily before breakfast. On 5/20/17, a physician's order was written for R196 to receive Humalog insulin 3 units daily before breakfast and to HOLD if not eating. This order was in addition to the Humalog SSI coverage before meals which was also written on 5/20/17 and stated to HOLD if not eating. Review of the MAR revealed that R196 received Humalog 3 units daily, signed off as given at 6:30 AM, from 5/20/17 through 6/13/17. Additionally, the MAR revealed that R196 received Humalog SSI coverage on the following dates: 5/23/17, 5/27/17, 5/28/17, 5/29/17, 5/30/17, 6/4/17, 6/6/17, 6/11/17, and 6/12/17. The facility failed to ensure that R196 was eating breakfast before administering the Humalog insulin as it was being administered by the night shift, who were off duty at 7:30 AM, and breakfast was not delivered until 8:10 AM, a potential one and three quarter hour delay. On 6/13/17, R196 had in total, the following insulin orders before breakfast: - Basaglar KwikPen insulin 6 units daily;	F 333	hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. Example 6 A. R91 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used	

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	085004	A. BUILDING _____ B. WING _____	C 07/19/2017

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F 333	Continued From page 48 - Humalog insulin 3 units daily, to be held if not eating; - Humalog SSI coverage, amount dependent on Accu-Chek result and to be held if not eating. Review of the 6/13/17 MAR revealed R196 received the following insulin before breakfast: - Basaglar KwikPen 6 units, signed off given by the day shift (7 AM - 3:30 PM) nurse; - Humalog 3 units, signed off by the night shift nurse at 6:30 AM. Despite the fact that it was to be held if not eating. Breakfast trays are scheduled to be delivered to the wing at 8:10 AM, potentially one and three quarter hours after administration of the fast acting Humalog insulin. Humalog SSI coverage was not given, as R196's 6:30 AM Accu-Chek was 82 and no coverage was ordered. Review of the meal intake record for 6/13/17 revealed R196 consumed only 25% of breakfast. A progress note, dated 6/13/17 and timed 11:54 AM, stated, "This nurse was called to the resident room...BS 54. Glucagon was given x 2. Resident was rechecked and BS was 175. Resident was seen by NP (name) and advised to be sent to ER for further evaluation." The facility failed to ensure that R196's insulin orders were followed when on multiple occasions insulin was administered when nursing staff was unaware if the resident was eating and they failed to administer fast acting insulin (Humalog) according to manufacturer's specifications. R196 was admitted to the hospital from 6/13/17 through 6/29/17. A hospital progress note, dated 6/28/17, stated, "...difficult to control...diabetes...dose has been altered multiple	F 333	as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process.	

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F 333	Continued From page 49 times...usually indicative of an acquired disorder, rather than having any connection with food intake or activity. It is very difficult to control..." R196 returned to the facility on 6/29/17. Readmission physician orders, dated 6/29/17, included: - Humalog SSI coverage before meals, dependent on Accu-Chek results and hold if not eating; - Humalog 3 units before breakfast, hold if not eating; - Nepro 8 ounces three times a day, timed on the MAR for 6:30 AM, 11:30 AM and 9:00 PM. The MAR revealed that R196 received Humalog 3 units daily, signed off given at 6:30 AM and Humalog SSI coverage on 7/4/17, 7/9/17, 7/10/17, and 7/12/17 at 6:30 AM. Both of these insulin orders stated to hold if not eating, however both were signed off at 6:30 AM and breakfast was not delivered to the unit until 8:10 AM. Observation on 7/12/17 at 8:00 AM revealed R196 asleep in bed with an unopened can of Nepro on the over bed tray table next to her. On 7/18/17 at approximately 4:15 PM, findings were confirmed by E1 and E2. During an interview on 7/19/17 at approximately 4:00 PM, E3 (RN, Staff Educator) stated that Nepro was timed to be given at 6:30 AM in an attempt to decrease R196's episodes of low blood sugars. When E3 was told of the observation on 7/12/17 at 8:00 AM of an unopened can of Nepro, she stated that the nurse needs to ensure the resident drinks it.	F 333		

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F 333	Continued From page 50 1C. Review of the facility's B Wing Nourishment List revealed that R196 was listed as receiving an assorted 8:00 PM snack. Review of the clinical record lacked documented evidence that R196 was receiving and/or consuming the bedtime snacks. During an interview on 7/19/17 at approximately 11:15 AM, E16 (RD) stated that bedtime snacks are not documented in the clinical record, however if a resident refuses or does not consume, it should say so in a nurse's progress note. 2. Review of R71's clinical record revealed the following: R71 was admitted to the facility on 3/28/17 with diagnoses including diabetes mellitus. R71 had a physician's order, dated 4/27/17, for Humalog SSI coverage before meals and at bedtime. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to B wing (where R71 resided) at 8:10 AM. Review of the April, May, June and July 1-19, 2017 MARs revealed that Accu-Cheks were completed by the night shift (11 PM- 7:30 AM) and signed off at 6:30 AM. Although Accu-Cheks may have been completed closer to 7:30 AM and SSI coverage given at that time, there was still a delay of approximately 40 minutes before breakfast was served. R71 was receiving Humalog, a fast acting insulin, which is to be	F 333		

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F 333	Continued From page 51 given within 15 minutes before a meal or immediately after a meal. Review of the April 1- July 19, 2017 MARs revealed that R71 received SSI coverage, signed off at 6:30 AM on the following dates (except 5/20- 5/24/17 when in hospital) : 4/29, 4/30, 5/1-5/3, 5/5-5/19, 5/25-5/31, 6/1-6/30, 7/1-7/19/17. 3. Review of R40's clinical record revealed the following: R40 was admitted to the facility on 12/30/16 with a diagnosis of diabetes mellitus. R40 had a physician's order, dated 5/15/17, for Novolog SSI coverage before meals and at bedtime. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to C wing (where R40 resided) at 7:50 AM. Review of the May, June, and July1-19, 2017 MARs revealed that R40 received SSI coverage, signed off at 6:30 AM on the following dates (except 5/2- 5/15/17 when in hospital): 7/3 and 7/17/17. Although Accu-Cheks may have been completed closer to 7:30 AM and SSI coverage given at that time, there was still a delay of approximately 20 minutes before breakfast was served. R71 was receiving Novolog, a fast acting insulin, which is to be given within 5-10 minutes of a meal. 4. Review of R181's clinical record revealed the following:	F 333		

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F 333	Continued From page 52 R181 had a physician's order, dated 1/23/17, for Humalog SSI coverage before meals for diabetes mellitus. R181 also had a physician's order, dated 1/23/17, for Humalog insulin 8 units daily and hold for blood sugar less than 100 for diabetes mellitus. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to C wing (where R181 resided) at 7:50 AM. Review of the April, May, June, and July 2017 MARs revealed that Accu-cheks were completed by the night shift (11:00 PM- 7:30 AM) and the Humalog SSI if received, was signed off at 6:30 AM. Although Accu-Cheks may have been completed closer to 7:30 AM and SSI coverage given at that time, there was still a delay of 20 minutes before breakfast was served. R181's standing order of 8 units of Humalog insulin if received was signed off at 7:30 AM. R181 was receiving Humalog, a fast acting insulin, which is to be given within 15 minutes before a meal or immediately after a meal. 5. Review of R117's clinical record revealed the following: R117 had a physician's order, dated 1/8/17 and discontinued on 5/25/17, for Novolog insulin 10 units daily and hold for blood sugar less than 100 for diabetes mellitus. R117 had a physician's order, dated 5/26/17, for Novolog insulin 11 units daily 10-15 minutes prior to meal and hold for blood sugar less than 100. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to B wing (where R117 resided) at 8:10 AM.	F 333		

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F 333	Continued From page 53 Review of the April, May, June, and July 2017 MARs revealed that Accu-cheks were completed by the night shift (11:00 PM- 7:30 AM) and the Novolog insulin, if received, was signed off at 6:30 AM. Although Accu-Cheks may have been completed closer to 7:30 AM and Novolog insulin given at that time, there was still a delay of 40 minutes before breakfast was served. R117 was receiving Novolog, a fast acting insulin, which is to be given within 5-10 minutes before a meal (although ordered to be given 10-15 minutes before meal). 6. Review of R91's clinical record revealed the following: R91 had a physician's order, dated 4/18/17, for Novolog SSI coverage before meals for diabetes mellitus. Review of the dietary meal delivery schedule revealed that breakfast trays were delivered to B wing (where R91 resided) at 8:10 AM. Review of the April, May, June, and July 2017 MARs revealed that Accu-Cheks were completed by the night shift (11:00 PM- 7:30 AM) and the Novolog insulin sliding scale, if received, was signed off at 6:30 AM. Although Accu-Cheks may have been completed closer to 7:30 AM and Novolog insulin given at that time, there was still a delay of 40 minutes before breakfast was served. R91 was receiving Novolog, a fast acting insulin, which is to be given within 5-10 minutes before a meal. All findings for this citation were reviewed with E1 (NHA) and E2 (DON) during the exit conference	F 333		

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F 333	Continued From page 54 on 7/19/17 at approximately 6:45 PM.	F 333		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 428		8/28/17

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F 428	Continued From page 55 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to act on an irregularity identified by the consultant pharmacist during the monthly drug regimen review for one (R112) out of 55 Stage 2 sampled residents. Findings include: Review of R112's clinical record revealed: 2/7/17- R112 was being treated for anemia with the medication Epogen. R112's monthy drug regimen review had a pharmacist recommendation that stated due to the resident currently receiving Epogen, which uses up the body's iron stores, to consider checking blood iron stores or starting iron therapy. 2/10/17- The physician checked agree for the pharmacists recommendation, dated 2/7/17, and wrote for Iron 325 mg by mouth twice daily. During clinical record review an order for iron 325 mg was not found.	F 428	A. R112 suffered no untoward effect and no longer resides at the facility. B. All residents have the potential to be affected. C. Pharmacy consultant recommendation form will be revised to include Unit Manager/Supervisor signature after physician determines course of action as a second check to ensure accuracy of orders documented in the medical record. All licensed staff will be in-serviced by August 28th. D. Staff developer/designee will review 100% of recommendation forms within seven days of receipt from pharmacy consultant for accuracy monthly until 100% compliance is achieved for three consecutive months. Pharmacy consultant will continue to report compliance quarterly through the facility QAPI process.	

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F 428	Continued From page 56 7/19/17 9:07 AM- Interview with E3 (RN, Staff Development) revealed the unit manager had the responsibility to review the monthy drug regimen review recommendations after the physician reviewed them and to enter all written orders. E3 reviewed R112's clinical record and confirmed that R112 does not have an order for iron 325 mg. 7/19/17 2:45 PM- The findings were reviewed and confirmed with E2 (DON) and E3.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431		8/28/17

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F 431	Continued From page 57 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record reviews, interviews, review of facility documentation and the manufacturer's medication guide, it was determined that for 6 [R17, R38, R136, R142, R152, R88] out of 55 Stage 2 sampled residents, the facility failed to provide pharmaceutical services to meet the needs of each resident. It was determined that for 5 (R17, R38, R136, R142 and R152) out of 5 residents who were prescribed Vimpat, a controlled medication used for seizure disorders, the facility failed to have an	F 431	Example 1a. A. R17 no longer resides at the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of	

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F 431	Continued From page 58 effective system using the Controlled Drug Receipt/Record/Disposition Forms (accountability records) that accurately accounted for, reconciled and recorded the disposition of controlled medications. In addition, the facility failed to dispose of R17's remaining Vimpat medication 72 hours after she was discharged from the facility in accordance with the facility pharmacy policy. For R88, the facility failed to ensure the correct labeling of a medication in accordance with currently accepted professional principles. Findings include: 8/14 - The Vimpat Medication Guide approved by the U.S. Food and Drug Administration (https://www.vimpat.com/vimpat-medication-guide.pdf) stated, "...4. VIMPAT is a federally controlled substance ... because it can be abused or lead to drug dependence...". 1/1/16 - The facility pharmacy policy entitled, "Controlled Medications" stated, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations...D. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose, completed after the medication is actually administered. E. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the	F 431	controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 1b. A. R17 no longer resides at the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 59 container. It must be destroyed according to facility policy and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets...". 1/1/16 - The facility pharmacy policy entitled, "Controlled Medication Disposal" stated, "...C. Destruction of...discharged or deceased resident controlled medication shall be jointly performed by two authorized licensed personnel within 72 hours of the discontinuation or discharge. D. A record of the destruction must be signed by both parties. This document becomes part of the resident's permanent medical record...". Cross refer to F281, example 1 1a. Review of R17's clinical record revealed the following: 5/16/17 - R17 was admitted to the facility with diagnoses that included a seizure disorder. 5/16/17 - A physician's order stated to administer Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R17's accountability record for Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - Wednesday, 5/17/17, AM dose; - Thursday, 5/18/17, AM dose. 5/18/17 through 5/25/17 - R17 was hospitalized for an unrelated medical issue and returned to the facility.	F 431	Example 2 A. R38 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 3 A. R136 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as	

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F 431	Continued From page 60 5/25/17 - A physician's order stated to administer Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R17's accountability record for her Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - Saturday, 5/27/17, AM dose; - Sunday, 5/28/17, AM dose; - Sunday, 5/28/17, PM dose. Review of R17's May 2017 eMAR revealed that licensed nursing staff administered and signed off the 5 doses of Vimpat medication listed above. It was unclear why R17's accountability forms did not match her eMAR and account for the 5 doses administered when the accountability form clearly stated, "Every dose must be accounted for and requires charting on the Medication Administration Record." The facility failed to ensure that licensed nursing staff accounted for and reconciled every dose of Vimpat medication for R17. 1b. R17 was sent to the hospital on 6/2/16 at 11:50 PM. 6/8/17 at 4:06 PM - A social service note stated that R17 passed away in the hospital on 6/6/17 and her family picked up her belongings on 6/6/17. Review of R17's accountability form for her Vimpat medication revealed that from 6/9/17 through 6/19/17 a total of 14 tablets were signed out as "wasted" by either one or two licensed nurses. It was unclear why the facility failed to remove R17's Vimpat medication within 72 hours	F 431	destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 4 A. R281 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	

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F 431	Continued From page 61 after she left the facility on 6/2/17. On 7/18/17 at 10:54 AM, surveyor met with E2 (DON) and E3 (RN/Staff Ed) to find out why 14 tablets of R17's Vimpat medication were signed off as "wasted" on her accountability record after R17 was discharged from the facility. E2 and E3 stated they would look into it and follow-up with surveyor. During a follow-up interview with E2 and E3 on 7/18/17 at 1:50 PM, E3 stated that licensed nursing staff administered R17's Vimpat medication to other residents, including R142. With the exception of R142, it was unclear on R17's accountability record the other residents who received the remaining 11 tablets. Findings were reviewed with E2 and E3 on 7/19/17 at 3 PM. The facility failed to dispose of her remaining Vimpat medication 72 hours after she was discharged from the facility in accordance with the facility pharmacy policy. 2. Review of R38's clinical record revealed the following: 6/27/16 - A physician's order stated to administer Vimpat 150 mg tablet two times a day for a seizure disorder. Review of R38's accountability record for Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - Thursday, 6/8/17, PM dose; - Friday, 6/23/17, AM dose. Review of R38's June 2017 eMAR revealed that	F 431	Example 5 A. R152 suffered no untoward effect and continues to reside in the facility. Staff identified with regard to the deficient practice was disciplined for failing to follow appropriate policy and procedure. B. Any resident receiving a controlled substance has the potential to be affected. C. Licensed staff will be re-educated regarding appropriate ordering, administration and documentation of controlled substances as well as destruction of discontinued medications by August 28th. Staff will also be educated concerning the pharmacy policy of medication availability 24 hours per day. D. The DON/designee will reconcile controlled substance documentation for actual medications on hand daily x 14 days, weekly times 10 until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 6 A. R88 received the correct dose of insulin per physician order with no untoward effect. R88 continues to reside in the facility. B. All residents receiving insulin have the potential to be affected. C. Licensed staff will reconcile insulin orders with insulin label provided by pharmacy to ensure accuracy. All licensed staff will be re-educated regarding reconciliation of insulin orders by August 28th.	

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F 431	Continued From page 62 licensed nursing staff administered and signed off the 2 doses of Vimpat medication listed above. It was unclear why R38's accountability forms do not match her eMAR and account for the 2 doses administered when the accountability form clearly stated, "Every dose must be accounted for and requires charting on the Medication Administration Record." The facility failed to ensure that licensed nursing staff accounted for and reconciled every dose of Vimpat medication for R38. 3. Review of R136's clinical record revealed the following: 4/26/17 - A physician's order stated to administer Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R136's accountability records for Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - Friday, 5/26/17, PM dose; - Friday, 6/9/17, PM dose; - Saturday, 6/10/17, AM dose; - Saturday, 6/10/17, PM dose; - Sunday, 6/11/17, AM dose; - Sunday, 6/11/17, PM dose; - Monday, 6/12/17, AM dose. Review of R136's May and June 2017 eMARs revealed that licensed nursing staff administered and signed off the 7 doses of Vimpat medication listed above. It was unclear why R136's accountability forms did not match her eMAR and account for the 7 doses administered when the accountability form clearly stated, "Every dose must be accounted for and requires charting on	F 431	D. Staff developer/designee will audit 100% of existing insulin orders and dispensed vials to ensure accuracy by August 28th. Staff developer/designee will then review weekly until 100% compliance is achieved for 3 consecutive months. Results will be reported quarterly through the facility QAPI process.	

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F 431	Continued From page 63 the Medication Administration Record." The facility failed to ensure that licensed nursing staff accounted for and reconciled every dose of Vimpat medication for R136. 4. Cross refer F281 example #2 Review of R142's clinical record revealed the following: 6/16/17 - A physician's order stated: to administer Vimpat 100 mg tablet one time only for one day; then Vimpat 150 mg tablet two times a day for two days; then Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R142's accountability records for Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - Friday, 6/16/17, PM dose; - Saturday, 6/17/17, AM dose; - Saturday, 6/17/17, PM dose; - Sunday, 6/18/17, AM dose; - Sunday, 6/18/17, PM dose; - Monday, 6/19/17, AM dose; - Wednesday, 6/28/17, PM dose. Review of R142's June 2017 eMAR revealed that licensed nursing staff administered and signed off the 7 doses of Vimpat medication listed above. It was unclear why R142's accountability forms did not match his eMAR and account for the 7 doses administered when the accountability form clearly stated, "Every dose must be accounted for and requires charting on the Medication Administration Record." The facility failed to ensure that licensed nursing staff accounted for and reconciled every dose of Vimpat medication for R142.	F 431		

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F 431	Continued From page 64 5. Review of R152's clinical record revealed the following: 2/16/16 - A physician's order stated to administer Vimpat 200 mg tablet two times a day for a seizure disorder. Review of R152's accountability records for Vimpat medication revealed a lack of evidence of accurate accounting by licensed nursing staff for the following dates and times: - 6/12/17, PM dose; - 6/13/17, AM dose. Review of R152's June 2017 eMAR revealed that licensed nursing staff administered and signed off the 2 doses of Vimpat medication listed above. It was unclear why R152's accountability forms did not match his eMAR and account for the 2 doses administered when the accountability form clearly stated, "Every dose must be accounted for and requires charting on the Medication Administration Record." The facility failed to ensure that licensed nursing staff accounted for and reconciled every dose of Vimpat medication for R152. Findings were reviewed with E2 (DON) and E3 (RN/Staff Ed) on 7/19/17 at 3 PM. The facility failed to have an effective system in place using the Controlled Drug Receipt/Record/Disposition Forms (accountability records) that accurately accounted for, reconciled and recorded the disposition of controlled medications for 5 residents (R17, R38, R136, R142 and R152). In addition, the facility failed to dispose of R17's remaining Vimpat medication 72 hours after she was discharged from the facility.	F 431		

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F 431	Continued From page 65 6. During medication administration observation for R88 on 7/18/17 at 8:30 AM, it was observed that R88's Lantus Insulin was labeled incorrectly. The label stated the opposite, to inject 30 units subcutaneously in the morning and 10 units subcutaneously at bedtime. The physician's order, dated 5/24/17, stated to inject 10 units subcutaneously in the morning and 30 units at bedtime. During an interview on 7/18/17 at 8:30 AM, E9 (LPN) confirmed that the Lantus Insulin was labeled incorrectly. The findings were reviewed with E2 (DON) and E3 (RN, Staff Development) on 7/19/17 at 2:45 PM.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		8/28/17

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F 441	Continued From page 66 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 67 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure proper infection control techniques during medication administration for two (R39 and R72) out of 55 Stage 2 sampled residents. Findings include: 1. During medication administration for R39 on 7/13/17 at 9:50 AM, E8 (LPN) was observed touching the trash can lid on the medication cart when throwing out trash and then continuing to touch medications and the medication cart without hand sanitizing or washing his/her hands. 2. During medication administration for R72 on 7/13/17 at 1:45 PM, E8 was observed touching the trash can lid on the medication cart when throwing out trash and then continuing to touch medications and the medication cart without hand sanitizing or washing his/her hands. During an interview with E8 on 7/18/17 at 1:50 PM, the findings were reviewed and confirmed. The findings were reviewed with E2 (DON) and E3 (RN,Staff Development) on 7/19/17 at 2:45 PM.	F 441	Example 1 A. R39 suffered no untoward effect and continues to reside in the facility B. All residents have the potential to be affected. C. All licensed staff will be re-educated regarding medication administration to include proper hand washing techniques by August 28th. D. Staff developer/designee will observe medication pass to ensure proper medication administration and hand washing techniques daily for 14 days and then weekly times two, then monthly until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process. Example 2 A. R72 suffered no untoward effect and continues to reside in the facility B. All residents have the potential to be affected. C. All licensed staff will be re-educated regarding medication administration to include proper hand washing techniques by August 28th.	

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F 441	Continued From page 68	F 441	D. Staff developer/designee will observe medication pass to ensure proper medication administration and hand washing techniques daily for 14 days and then weekly times two, then monthly until 100% compliance is achieved. Results will be reported quarterly through the facility QAPI process.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 520		9/11/17

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F 520	Continued From page 69 (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to have a quality assurance program that identified and corrected quality deficiencies. Findings include: Cross refer F333 The facility failed to identify that fast acting insulins were being administered by the night shift when breakfast was not being delivered from 1/2 to 1 and 1/2 hours later. This QAA [quality assessment and assurance committee] did not identify that this deficient practice had the potential of placing six (R40, R71, R91, R117, R181, and R196) residents at risk of developing hypoglycemia. Findings were confirmed with E3 (RN Staff Educator) during an interview on 7/19/17 at approximately 4:00 PM.	F 520	A. R40 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI	

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F 520	Continued From page 70	F 520	process. A. R71 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. A. R91 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been	

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F 520	Continued From page 71	F 520	revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. A. R117 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 72	F 520	compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. A. R181 suffered no untoward effect or hypoglycemic events, continues to reside in the facility and be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process. A. R196 continues to reside at the facility and continues to be monitored per physician order. B. All residents requiring short acting insulin have the potential to be affected. C. All residents receiving short acting insulin have individualized orders that	

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F 520	Continued From page 73	F 520	reflect meal accessibility times based on location of residence. Orders have been revised to reflect insulin administration with meals. A supplement may be used as a meal replacement after a tray has been offered per resident preference as determined by the IDT. All nursing staff and registered dieticians will be in-serviced regarding the revised procedure. D. Tray pass and insulin administration will be monitored by unit manager/designee daily x 14 days, then twice weekly, then quarterly until 100% compliance has been observed for two consecutive quarters. Results will be reported through the facility QAPI process.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

FACILITY: Brandywine Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: July 19, 2017**

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from July 11, 2017 through July 19, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 166. The Stage 2 survey sample size was 55.	**Disclaimer Statement:** Preparation and/or execution of this plan of correction (POC) does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State laws.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	Please refer to the electronic POC on the 2567-L survey report submitted via the Aspen web portal for the survey ending 7/19/17 for F241, F253, F257, F258, F279, F281, F309, F312, F323, F327, F329, F333, F428, F431, F441, and F520.	9-11-2017
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed on July 19, 2017: F241, F253, F257, F258, F279, F281, F309, F312, F323, F327, F329, F333, F428, F431, F441, and F520.		

Provider's Signature _____ Title ADMINISTRATOR Date 8/31/2017